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President of the Ulster Medical Society 2014–15

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SPECIALISING IN GENERALISM

I have looked back at many of the addresses given by past presidents and have decided that as my theme for the year is "*Making a Difference*" that I should give a different form of Presidential Address. I am therefore going to take you on a journey of "my life and what I do." So who am I and what do I do? I am Colin Mathews, GP Principal in Portadown from 1985 and Sexual Health Practitioner in Belfast and Newry from 1985, and have spent some time as a GP Tutor and appraiser. I work in a "state of the art" Health Care Centre in Portadown.

Having just been at my 35-year Medical Reunion and as I reflect on those years I realise that there have been many significant influences in my life and I wish now to highlight three of those medical influences.

The first influence was ancestral:



These three great-grand uncles of mine, the three youngest sons of seven children born to John Mathews and Margaret Wallace of Corkey, Co Antrim, were sent to Queens College in the 1880s to study medicine. At Queens the secretaries knew the three brothers for always reminding them that Mathews only had "one t" … a trait that continues to the present day.

These three Mathews medics on qualifying headed to Sheffield where they established themselves as General Practitioners. These medics earned a great reputation in Sheffield and the practice is still in existence today and is called "The Mathews Practice".

As well as making a difference in Sheffield these doctors started a family tradition of medicine, which has seen at least 46 doctors qualify mostly from Queens and Sheffield Universities. I am pleased that some of these medics are in the audience tonight and coming up last is my son Kyle at N$^{o.}$ 46.

The second significant influence in my life as a person and as a doctor was my father. He started a single-handed practice in 1948 in Portadown, building premises for the practice beside his house. He was very much the Dr Finlay in his young day and matured and stopped working at age 76 as Dr Cameron. Even when he retired he still kept in touch with his patients. In fact the practice manager when asked had Dr Mathews senior not retired she said "Oh yes he has, he has just forgotten to go home."

He was an avid anti-smoking campaigner and he abhorred the overuse of antibiotics. As a consequence our practice has a low prevalence of COPD and has always had extremely good antibiotic prescribing figures. Dad was a wonderful role model for my brother, Kenneth, and myself as we chose medicine and general practice as our careers.

The third and certainly the most significant influence in my life generally and my role as a general practitioner is that of my late wife Trish. Her role in the medical practice frankly was immeasurable and I have altered the words from a poem of WB Yeats, which neatly sum up how she was viewed by her patients.

"Paediatrician, Psychiatrist, Physician she,
And all she did done perfectly.
As if she had that one skill alone."

As I went through my training and early postgraduate jobs in the Royal I dabbled with the idea of other specialities:

Cardiology: I realised however that I had no future in Cardiology when Professor Pantridge thought I was safer going to collect cheques for "The Heart Fund" than working on the wards.

Surgery: Despite having a wonderful SHO, our esteemed former president, I knew I could never be a surgeon as the excitement might be too much for me! … as is clearly shown on his face. I also preferred eating sandwiches with the consultant rather than doing the work!

Medical Education: I always enjoyed teaching and have combined GP and Sexual Health teaching with

my General Practice work.

The one other career was Venereology (aka Genitourinary Medicine and more recently Sexual Health). This job suited me really well as I loved the opportunity to "diagnose and cure all in one go" that GU Medicine gave me. I have been lucky to have been able, however, to continue with sexual health on a sessional basis working for many years in the Royal and Newry. But when it came to making a career choice I looked at what I was best suited to do.

Generalism or Specialism? "A generalist species is able to thrive in a wide variety of environmental conditions and can make use of a variety of different resources. A specialist species can only thrive in a narrow range of environmental conditions or has a limited diet."

So I explored the characteristics required for each role and knowing I had generalist traits and enjoying the variety of different jobs I decided that General Practice in Portadown was the choice for me.

So after a brief Trainee Year in Ballymoney and a brief spell in Nassau, Bahamas I returned to work in Portadown in 1985. General Practice however is a job that changes in every generation and the GPs of today do a very different job than those of our predecessors. The practice of my Sheffield ancestors was very different to the General Practice of today.

In the 19th century General Practitioners had evolved from apothecaries and provided community based medicine, dealing with any health problem that was brought to them and occasionally referring to hospital-based physicians or surgeons. Most practitioners worked single-handedly or in pairs and often from a small Surgery attached to their house.

Payment was made by the patient on a fee for service basis and General Practitioners lived in their community and were credited with knowing everything about medicine and health and were important pillars of the community.

With the introduction of the National Health Service in 1948 and GP Lists and provision of free Healthcare, GPs became gatekeepers to the health service and the boundaries between GPs in primary care and hospital consultants in secondary care were firmly fixed. This division continues to this day and often it is detrimental to the overall care of the patient.

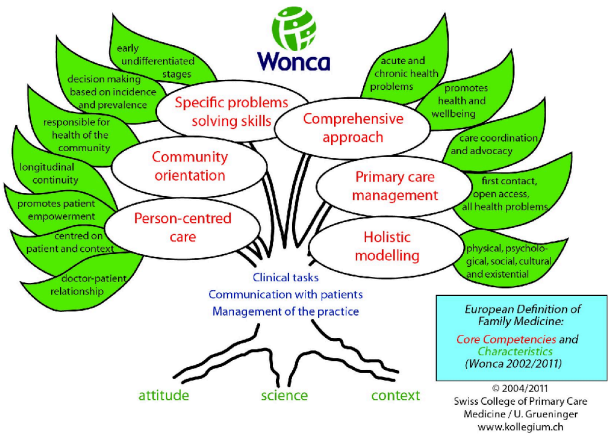
Gradually the later half of the 20th century and early 21st century saw future General Practitioners receive appropriate post-graduate training; move into "fit for purpose" premises; developed shared working practices with nurses and other professions allied to medicine; embrace all the nuances of computerisation and IT; accept targets and performance related pay.

During this time the role of primary care expanded so that practice teams now look after a whole range of necessary preventative health services, screening services and chronic disease management, and are the teams who are called upon by the CMO when new vaccination programs are introduced or we are threatened by pandemics.

The range of skills required is enormous. Specialists in:

Preventative Care & Health Promotion
Early Diagnosis and Management
Acute conditions and medical emergencies
Management of undifferentiated illness
Chronic Disease Management Palliative Care and helping our patients die with dignity
Complex multi-co morbidly
Coordination of the health care team
Judicious use of finite medical resources
Business management and employment skills

Our work as Primary Care Doctors is summarised very well by a look at the Wonca Tree.



In Northern Ireland we now have 1,165 GPs (an 8.6% increase in the last 15 years). This compares to 1,542 hospital consultants (88% increase in last 15years)

These GPs and locums provide 12.4 million consultations per year, print 38 million prescriptions per year and have witnessed a 60% increase in tests over the past decade.

The difficulty and complexity of our job is summarised by Martin Donohoe, MD, FACP, an Adjunct Associate Professor in the Department of Community Health at Portland State University, who said "The range of undifferentiated problems, or non-disease, that the generalist encounters inevitably creates an inherently uncertain environment, in which the generalist calls on an extended set of management skills, using time to reveal the natural course of a problem.

As well as our health care disease work we have become the perceived arbiter of allowance decision making.... DSS needs health reports on our patients. Employment Support Agency needs health reports on our patients. In fact it seems that no government agency can make a decision without a health summary and opinion from a patients GP.

Above all the thing that infuriates me the most and I am sure I speak for all the GPs in the audience are the insatiable demand for referral letters to every possible agency:

> Jennifer, from Community Occupational Therapy came to desk to say that Mrs P was seen in hospital by OT who provided a toilet support rail and so will now need a referral to community OT to get a raised toilet seat.
>
> Nursing home need a referral to S&LT because 102 year old Mrs Jones spluttered and choked on her breakfast.

Here are examples of needless waste-of-time referrals and the GAWLFYD[1] requests:

> Teachers—granny sick when child doing exams.
>
> Employers—worker does not like supplied footwear.
>
> Housing Associations—child has asthma so needs central heating.
>
> Gyms—Is patient fit to exercise?
>
> Beauticians—is patient fit to have electrolysis?

When I now look at what I have become in present day general practice I realise it is a long way removed not only from the 1890s Sheffield Practice but also far removed from the General Practice that I trained for in 1983. I wanted to be and thought I was a generalist but am now becoming a multi-faceted specialist and this is an impossible task.

Society and our defence organisations demand that GPs appear and are expert in every disease management process as we are often left without appropriate support from secondary care due to long waiting lists and barriers to 2nd opinions.

It is a long way removed from the generalist ideals of Hippocrates. The patient, not the disease, was to be treated, and to treat the patient well, the physician was to examine him or her as a whole, not merely the organ part in which the disorder was located. “It is more important to know what sort of person has a disease than to know what sort of disease a person has.” Hippocrates’s Oath and formula of care thus provide the underpinnings of generalism and a generalist approach to health care that can be called a philosophy of practice.

It is clear that a disjuncture between generalism and specialism has existed for long periods in human history. It is a disjuncture that has largely rested on philosophical differences whereby the kind of person a generalist is, the values which shape their personal character and the principles which guide their practice have been largely overlooked.

In addition to this, there has been a growing emphasis on tangible and measurable outcomes which has seen the holistic and less measurable values and principles of a generalist approach overlooked and undervalued.

Generalists have the breadth of knowledge to be able to survey the big picture and identify critical problems and goals, but they may not have the specialist knowledge to solve the problem or execute the plan. Generalists and specialists must put the patient first, play complementary roles and not create barriers to shared working and allow easy access to specialist advice.

This debate about generalism and specialism has been brought together by a commission on generalism with the report published by the Royal College of General Practitioners in 2012. This is an important document and will hopefully influence politicians, medical student training and the delivery of care. Andy Burnham at BMA in July said “The NHS needs a new generation of generalist doctors working in single clinical teams that would be led by a generalist doctor and these teams would be based on a patients needs.”

[1] “Get a wee letter from your doctor”